

## Anesthesia Adverse Events Annual Report U.C.A. § 26-1-40

## **Center for Health Data and Informatics**

## **BACKGROUND**

In the 2017 Legislative year, HB 142 Anesthesia Amendment was passed which requires healthcare providers licensed under the Utah Code, Division of Professional Licensing (DOPL) Title 58 (Sections 58-5a-502 (Podiatrists), 58-31b-502.5 (Nurses & Nurse Practitioners), 58-67-502.5 (Physicians and Surgeons), 58-68-502.5 (Osteopaths) and 68-69-502.,5 (Dentists and Dental Hygienists) to report IV sedation related adverse events that occur in the outpatient setting (non-Hospital and non-Ambulatory Surgical Centers) to the Utah Department of Health. If a provider does not report these events, the DOPL law change has determined that "non-reporting" to be considered unprofessional conduct with subsequent consequences.

Over the 2017 summer, an interdisciplinary team of healthcare professionals (Podiatrists, Nurses, Certified Registered Nurses of Anesthetics, Anesthesiologists, Physicians and Surgeons, Dentists, Osteopaths and others) met to determine the rule set needed to operationalize HB 142. A set of administrative rules were filed and published for public comment with one change and have become effective April 14, 2018.

An online reporting database was developed to receive reports using REDCAP technology. The Patient Safety web site was update to include the law and rules related to how to report. In Spring of 2018 close to 15,000 providers were notified of the reporting requirement and procedures via email and 12,000 in a hard copy letter. Effective date for reporting to begin was set at July 1, 2018.

Several phone calls were received asking for clarification of the reporting requirements. Most of these questions were related to clarifying reporting requirements from those who work in hospitals and ambulatory surgical centers versus outpatient settings. Hospital and Ambulatory Surgical Centers are covered under the Patient Safety Rule R 380-200. This new law and rules apply to outpatient settings only. A second notification to all providers will be done summer 2019 as a reminder to report events. Data collected will be shared in the aggregate format to the user groups for feedback and analysis.



## ADVERSE EVENTS DATA

One death and one adverse event have been reported from July 1, 2018 through June 11, 2019.

Reporting Category	Patient 1	Patient 2
Event type	Death	Loss of consciousness and
		breathing.
Type of health care provider	General Dentist	Dentist
License category of person	CRNA	Doctor or Dental Surgery
submitting report		
Specialty of person submitting	Certified registered nurse	Dentist
report	anesthetist	
Person who administered sedation	Certified registered nurse	Dentist
or anesthesia	anesthetist	
Proceduralist specialty	General Dentist	Doctor or Dental Surgery
Proceduralist license type	Other	Dentist
Type of facility in which the death or	Anesthesia administered at	Physician's Office
adverse event took place	dental clinic, death occurred	
	several hours later at a hospital	